QUALITATIVE AND MIXED METHODS RESEARCH
https://doi.org/10.1071/HC24058

Rural hospital contributions to community health: community perspectives from a New Zealand rural hospital

Stephen Ram[A,*], Karen Carlisle[B], Sarah Larkins[B] and Katharina Blattner[C]

For full list of author affiliations and declarations see end of paper

***Correspondence to:**
Stephen Ram
Tokoroa Hospital, Te Whatu Ora (Health New Zealand) Waikato District, Maraetai Road, Tokoroa, New Zealand
Email: stephen.ram@my.jcu.edu.au

Received: 22 April 2024
Accepted: 24 June 2024
Published: 18 July 2024

Cite this: Ram S *et al.*
Journal of Primary Health Care 2024
doi:10.1071/HC24058

© 2024 The Author(s) (or their employer(s)). Published by CSIRO Publishing on behalf of The Royal New Zealand College of General Practitioners.
This is an open access article distributed under the Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License (CC BY-NC-ND)

OPEN ACCESS

ABSTRACT

Introduction. Rural hospitals provide secondary care for much of the rural New Zealand population. Little is known about community perspectives of the health and social contribution. **Aim.** This descriptive qualitative study aimed to explore community views on the role of their rural hospital in a low socioeconomic rural district with a high Māori and Pacific population. **Methods.** Semi-structured individual and focus group interviews were conducted with rural community members about the perceived role of their rural hospital. Iterative thematic analysis was undertaken. **Results.** In total, 22 participants were interviewed. Thematic analysis yielded four themes: (i) rural hospitals as a safety net – providing access to emergency care and mitigating limited primary care access; (ii) providing personalised, culturally aware care; (iii) facilitating family/whanau support; and (iv) doing the best with limited resources. The latter included pragmatism about resource constraints, but a preference for the hospital to remain open. **Discussion.** Rural hospitals contribute to community safety by enhancing access to emergency care and mitigating difficulties in access to primary care. The local contextual knowledge of rural hospital providers allows personalised, family-centred and culturally-responsive care. Despite service centralisation, rural hospitals are wanted by their communities. Rural health planners should consider how to maximise the breadth of locally-provided services to reduce the impacts of travel and transfer for care.

Keywords: community participation, community-institutional relations, health services evaluation, Maori health, Pacific health, rural health, rural hospital.

Introduction

Rural hospitals are estimated to serve approximately 10–15% of the New Zealand (NZ) population.[1] They provide emergency care and a range of multidisciplinary inpatient and outpatient secondary care services to communities that are located at a distance from urban centres.[1] Rural hospitals vary in size, governance model, range of services and access to diagnostics,[2] with some situated in communities with sizeable Māori and Pacific populations.[3] It is recognised that Māori, and in particular rural Māori, have poorer health outcomes compared to the general population.[4] Pacific people also have a disproportionate burden of cardiovascular disease, socioeconomic deprivation and health care access barriers.[5] Despite their prominence in the health system,[6,7] little is known about the activities and contributions of rural hospitals in NZ. Most of the research on rural hospitals in NZ has been focussed on workforce capacity and the development of the vocational scope of rural hospital medicine.[8]

In recent years, attention has been given in NZ to the perception of a so-called 'postcode lottery', where the same public health system appears to be delivering different health care depending on where in the country the consumer lives.[9] In response, the government has undertaken reform of the health system and legislated health strategies for vulnerable priority groups.[10] Efforts have also been made to define geographical catchment areas and population demographics.[11] For example, a fit-for-purpose rural geographical classification for use in health settings was developed in 2022,[12] and at a

WHAT GAP THIS FILLS

What we already know: Rural hospitals provide access to secondary care for rural patients, but little is known about their contribution to the health system or the community.

What this study adds: Rural communities see a role for rural hospitals to enhance access to emergency care and provide family support and personalised care that are respectful of cultural preferences.

similar time the first umbrella national rural health advocacy body (Hauora Taiwhenua) was formed.[13] The health reforms of the past 2 years are the first time a rural health strategy has been legislated in NZ.[10]

There is limited research on community perspectives of rural hospitals, and a particular need to understand perspectives of rural Māori and Pacific people as high-priority groups that continue to experience inequitable health outcomes.[4,14] In addition to being underserved, it is considered that these groups, and Māori in particular, experience systemic cultural biases in health care interactions[15] that create further barriers. Understanding consumer perspectives therefore informs service design that is patient-centred and culturally acceptable.

The aim of this study was to explore community views of the role of the rural hospital in a low socioeconomic rural district with a high Māori and Pacific population.

Methods

This descriptive qualitative study employed community engagement, data collection and member-checking phases. Ethics approval was granted by Otago University (H23/018).

Study setting

The study hospital is in a low socioeconomic rural community with a high Māori and Pacific population. Similar to other parts of NZ, hospital care is publicly funded and free of charge,[14] whereas primary care in this district often requires a co-payment.[16] While the rural hospital is co-located with two of the five primary care practices in the area, it is a separate service. Specialist care is provided in an urban centre approximately 90 km away and is difficult for community members without access to car transport to attend for care due to limited public transport.

Phase 1: community engagement

Existing networks and connections were used to establish and strengthen relationships with local stakeholders and community groups. This included Kaitiaki (Māori cultural support workers), key people in local Māori iwi (tribal) groups and the leadership of the local Pacific Island community health and social service.

Phase 2: recruitment, data collection and analysis

Participants were recruited into individual or focus groups for interviews, either as preferred by the participant themselves, or advised by stakeholders contacted during the engagement phase (eg a Pacific focus group was formed as a result of advice during phase 1). A mix of convenience and snowball sampling strategies[17] were used, based on response to limited community advertisement and invitation to participate through contact with those in the networks developed. It is unknown if anyone declined to participate. Advice was sought from Māori and Pacific Island stakeholders regarding culturally sensitive approaches to recruitment, interview settings and style, and refinement and piloting of interview questions. As a result, minor changes were made to the phrasing of some questions. During semi-structured interviews, participants were asked their opinions of the hospital's strengths and weaknesses, how they would be affected if unable to access local hospital care, and their opinions on services that would be desirable but are not currently provided.

A reflexive thematic analysis approach was used, as outlined by Braun and Clarke,[18] with a descriptive post-positive approach to theme development. Interview transcripts were coded, and annotations were added by the lead author to provide contextual details and assist with reflexive practice.[19] Themes and sub-themes were developed and agreed upon using an iterative process involving discussion between the lead author and the rest of the research team.

Phase 3: member checking

To enhance the trustworthiness of interpretations, member checking[20] was undertaken with three participants – one Māori, one Pacific and one from the general population. They were chosen on the basis of their responses to the demographic survey and invited to look over the preliminary themes with the lead author for refinement. Minor changes were made to the names of the themes as a result.

Researcher positionality

The lead author identifies as a male with NZ European and Fijian Indian ethnicity. He has limited qualitative research experience and adopted a post-positivist ontologic approach in this study.[21] He works as a doctor in the rural hospital studied, and during most of the study period he lived in the district served by the study hospital. He has provided medical care in the past for some of the participants. He therefore recognises his mix of insider and outsider perspectives,[22] having a privileged position as a local health professional but also being an outsider in terms of cultural identity to many participants. Participants had the option of being

interviewed remotely by one of the co-authors to mitigate issues created by this dual relationship; however, no participants opted for this. Reflexive notes were kept, and themes were developed in collaboration with co-authors who work outside the lead author's setting and are all experienced qualitative researchers.

Results

Demographic analysis

A total of 22 participants were interviewed (Table 1). Interviews consisted of a focus group of six Pacific participants, two small focus group interviews of two participants each and 12 individual interviews. Most participants (68%) were female, and 68% were aged between 31 and 64 years. Twenty-three percent of participants were Māori, and 36% were of Pacific ethnicity. Due to ethics requirements, the study community is not identified; however, it appears well represented for Pacific ethnicity but possibly underrepresented for Māori.

Table 1. Participant characteristics.

Demographics		*n*	%
Gender	Male	7	32
	Female	15	68
	Other, eg nonbinary	0	0
Age in years	18–30	0	0
	31–49	9	41
	50–64	6	27
	65–74	2	9
	>75	5	23
Ethnicity[A]	Pakeha/NZ European	10	45
	Māori	5	23
	Pacific	8	36
	Other	1	5
Occupational group	Factory	1	5
	Agriculture	2	9
	Health worker	4	18
	Health administration	3	14
	Management/Administration	1	5
	Retired	3	14
	Mother	1	5
	Unemployed/Beneficiary	2	9
	Not stated	1	5
Number of years living in community	<2	0	0
	2–5	2	9
	5–10	0	0
	10–20	4	18
	>20	16	73
Have you been hospitalised locally/attended the hospital for care?	Yes	21	95
	No	1	5
If yes, how long ago? (n = 21)	<3 months	9	43
	3–6 months	5	24
	6–12 months	4	19
	1–5 years	1	5
	>5 years	1	5
	Cannot recall	1	5

[A] n > 22 because some participants identified as more than one ethnic group.

Themes

Four themes were identified: rural hospitals as a health safety net; providing personalised, culturally aware care; facilitating family/whanau (extended family) support; and doing the best with limited resources. The themes are discussed below with illustrative quotes, and further quotes are presented in Table 2.

Rural hospitals as a health safety net

Participant responses suggest an important role for rural hospitals is provision of a safety net for emergency care and enhancement of access to health care. This concept of 'safety net' was described as the rural hospital being open all hours and in close proximity to where they lived:

> I think generally the community here is very grateful to have [study hospital] and very grateful for the staff up there. They find them good. The district nurse is wonderful. The hospital is a bit of a secure thing because it's a big thing now for where do you go? You can't just drive on up to [regional urban hospital] – that's too far, too cluttered. We are really lucky that we do have an A&E Department. (F, NZ European/Pakeha)

Being able to access care in an emergency was highly valued. Participants recognised that the hospital served a wide geographical area. They had a strong perception that the lack of ability to access hospital services locally and the need to then travel to an alternative hospital would have significant adverse health implications. Others would consider forgoing care altogether. A few participants emphasised the potentially hazardous nature of industries in the area, such as farming and manufacturing, and the need to have timely access in the event of an accident.

Participants also used the hospital for providing timely access to care where they perceived a primary care appointment was needed earlier than the offered wait time or where

Table 2. Themes and sub-themes with example quotes.

Theme	Sub-theme	Example quotes
Safety net	Emergency care close by	'It's very scary. A lot of people do come in by car because they don't think they're bad cos they don't know so knowing that there is somewhere here, that's open 24/7 in an emergency situation is very comforting, I think. I think we'd be screwed without a hospital.' (F, Māori)
	Serves a wide area	'The area that they cover though when you think about it, it's a massive area that [this rural] hospital actually covers, because it's the closest for [two surrounding towns adjoining district] – all those rural areas, [two other towns in the district] – they all come here as well most of the time.' (F, Māori)
	Lack of local access may have severe health consequences	'In my experience, just being here. There's been a few times where we've needed urgent care and if the hospital wasn't here … my daughter wouldn't be alive if the hospital wasn't here. She stopped breathing when she was seven days old, we rung 111 [emergency number] but because we lived out [rural address], they said the ambulance won't find us in time. We were told to get in the car and drive to the hospital. When we got here, they'd called ahead and there was nurses waiting at the door and everything. She wouldn't be alive if the hospital wasn't here. The service you get when you need it, is amazing'. (F, Māori)
	Forgoing hospital care if not provided locally	Interviewer: 'Say we didn't have [rural hospital] and you or family had to travel away out of the area to get to a hospital, how do you think that would affect you?'
		Respondent: 'To be honest, I probably wouldn't go … For myself, cos I'm a bariatric patient, it's the logistics of me getting to [urban centre with tertiary hospital], outside of an ambulance is quite hard so I love having a hospital here.' (M, Pacific)
	Timely primary care access	Participant 1: 'I always try the GP [general practitioner] first but depending on why you're sick, you can wait up to six weeks so by the time you progress in your sickness, you normally end up at [rural hospital emergency department].' (F, Māori)
	Stigma of using rural emergency department for minor issues	Participant 1: 'For my experience, the day that I came in and it wasn't an emergency, and I knew it wasn't but being made to feel like … I get that some people come just because it's easy and they come just because they can't be bothered trying a GP.' (F, NZ European/Pakeha)
		Interviewer: 'Although, having talked to you both, I can see why!'
		Participant 2: 'Yeah, there's no point.' (F, Māori)
		Participant 1: 'But sometimes you come in and you do feel like the nurses, even sometimes some doctors make you feel like you're not actually welcome here because you're not … even though you're feeling frustrated and you know that you're not meant to be there, you want the help, you just don't know where else to go or there's cost factors and then they make you feel like you're wasting our time, which is essentially what we already know by coming here but we don't wanna live with them.'
		Participant 2: 'That puts people coming off next time when they're actually gonna need to come.'
	Cost of primary care	Participant 1: 'You would come to [rural hospital emergency department] which, unfortunately, it's not really an emergency but it's the cost.' (F, NZ European)
		Participant 2: 'For that particular thing and then it's the availability for the GP side of things.' (F, Māori)
		Participant 1: 'In our area, it's cheaper than other places but it's still costly.'
		Interviewer: 'Relative to what's realistic.'
		Participant 1: 'Yeah, both of us are single parents, on single wages so it makes a huge difference.'
	After-hours system difficult to access	Participant 1: 'There used to be a number you could ring to find out where it is, and I don't even know if that exists anymore.' (F, Māori)
		Participant 2: 'I don't know, a couple of times I've rung that number, and it doesn't give you an option of where it is, it just …' (F, NZ European)
		Participant 1: 'So, then people will just come to [rural hospital emergency department]?'

(*Continued on next page*)

Table 2. (*Continued*)

Theme	Sub-theme	Example quotes
		Participant 2: 'Yeah.'
		Participant 1: 'The other night, my daughter, she's just had a baby, we needed to see a doctor, we could not figure out, my Mum drove her around the doctors' surgeries to try and figure it out, couldn't find it so she ended up at [rural hospital emergency department].'
	District nurse service as triage function	Participant: 'Normally [you'd try and see] your local GP but it's quite hard to get an appointment. Depending on your local GP, if it's not booked, if you have to wait a long time then a district nurse, then she tells me whether not to go to [rural hospital emergency department] or wait for my appointment.' (F, Pacific)
	Co-location with primary care	Participant: 'I think it's quite good that everything's all on one site. People can come here, if they do need to go to [the emergency department], it's not getting in a car and moving somewhere else; they can just get there and get the medications and everything all at the same time. I think that the perception of the service definitely got blurred with the co-location and I don't know a good thing or a bad thing, really.'
		Interviewer: 'Probably had unintended effects.'
		Participant: 'I think the idea to move all the GPs to one place was pretty good because they were quite spread out and they were less and less of them. Bringing them all together was probably the right thing to do. I'm not sure that the location would've made a difference – if they'd been together located in town or if they'd been together located here, I don't know that it would've made a difference.' (F, Other)
Facilitating family/whanau support	Accessibility for family members to provide support	'I suppose because we've got family back here, if it comes down to an emergency, then they'll come up and support you. Like I said, if it was here in [local rural hospital], it's a hop, skip and a jump and someone's there. It's a bit different when they ring up from [distant regional tertiary hospital] and say, "You need to get up here," and when they do get up there, sometimes they say, "Oh, it's alright now," so you spend an hour and a half getting up there for no reason at all. That's a bit discouraging.' (M, Māori)
	Ease of managing family affairs	'If I had a choice to have the treatment in [local rural hospital] or out of town, I would choose [local rural hospital]. It's a lot easier not only myself but my family and financially. Everything falls into place – my anxiety don't go through the roof, my pocket doesn't have a hole in it, and we can keep the routine similar to me being home; just they have to visit me in hospital which can still be on a daily, instead of once a week we'll go up to [urban hospital] and see Mum kind of thing.' (F, Pacific)
	Cost of distant hospitalisation on family/whanau	'For me, it would be loss of income cos I'm the only income earner in my family, with my partner not working. Finding childcare for my children, making sure that they were taken care of and taking time off work. If you take time off work, you don't get paid so if I don't get paid, we have no money and then we don't eat. That's a bit dramatic but you know what I mean.' (F, Pacific)
Providing personalised, culturally aware care	Catering to personal circumstances	'Yes. The difference with our local hospital is cos it's [local rural hospital], it's only 5/10 minutes away from home. You just explain to the nurses, "He [autistic son] just needs time with me before he goes home," and just as long as we can keep him to a minimum of distraction around with other patients, then they're quite lenient and will let him stay 'til 8 o'clock or whatever time visiting hours' done. It's a more personal touch being a smaller hospital, aye.' (F, Pacific)
		'For me, cos I'm a bariatric patient, privacy is a big thingy for me, I'm a very private person. If we, for example, in my day for myself, I like to have my curtains drawn cos I don't like people peering into me, that sort of stuff. Could be quite invasive and people, I think they don't do it intentionally, they just got a habit of looking at you through the doors when they're walking through past, so I tend to have my curtains drawn. They know that when I'm in there that that's how I like to have it and they're fine with it.' (M, Pacific)
	Culturally respectful practices	Pacific participant: 'I think they have some good cultural practices in there as well. I'm a culturalist so there's certain things in our culture that we do and they're very understanding about that ... Whenever I come into the hospital I always bring my bible with me cos that just brings me comfort and they leave me to do what I do, when I need to do it, to do with my religion. When it comes to the showering times, in our culture you don't mix males and females or like that and they're quite accommodating to that, if they can.' (M, Pacific)

(*Continued on next page*)

Table 2. (*Continued*)

Theme	Sub-theme	Example quotes
		'When we went up for our COVID tests and for our swabs and our injections and all that, they were so friendly. Getting into Māori now – their awhi (embrace). They make you feel good, they didn't make you go, "I don't wanna be here." They relax you. Brilliant. That was for the COVID.' (M, Māori)
	Cultural needs unmet	'The time we went in for my Dad, one of the nurses said to another patient, "You've got COVID." How is that professional, telling a whole room of people that this lady has COVID? Everyone's just like … and I've just brought my Dad in, who is also immunocompromised so where do you go from there? Where do you take them? What do you tell that lady? You need to leave. What do you do? That culturally, especially for men or especially for any Pacific Island person, they don't want everyone to know why they're there. Having a space away from the waiting room and away from other people, would probably be the best thing. Not just for Pasifika but for everybody.' (F, Pacific)
Doing the best with limited resources	Centralisation and decline of services	Participant: 'I was hospital aide here on night shift when the hospital first opened and [ex-surgeon] used to do night theatres and the hospital was always busy.'
		Interviewer: 'It was a lot bigger, wasn't it? Had more wards?'
		Participant: 'Yeah. Right down the end we had it as Ward 4, was a medical ward and we had a nice heart unit and they used to take ECGs [electrocardiograms] and send them off to Hamilton to be read by the specialist. It was quite a real nice little hospital and since we lost the surgery lot, it's gone down a bit.' (F, Māori, >75 years)
	Increasingly functions as stabilisation post prior to transfer	'It is, which is a shame, really, because they really need to beef up our hospital a little bit more, I think but because we're only a first aid outfit down here hospital. From here, they go straight through to [distant regional urban hospital] for the big stuff. They patch them up here and send them off and even our locals, myself, I had broken bones – in the ambulance off to [distant regional centre].' (M, Māori)
	Government and management decisions the reason for the decline	'Everything went to hell! Like our governments normally do. I don't know if you can blame them. They just chop this, chop that; they don't care for the people themselves. That's way I look at it. Our hospitals are very good. I won't denigrate our hospitals in any way or our doctors and our nurses, they do a marvellous job. They can only do what they can do.' (M, Māori)
	Resigned to managing with limited resources	'Yes, and that's noted by a lot of people who do comment that, "They've got all these empty offices and blah, blah, blah. Why can't they do this and that?" I just look at them and say, "Dollars and staff."' (F, NZ European)
	COVID-19 challenges to care delivery	'Yeah, and then the nurse came out probably another hour after that so I still had no pain relief at that stage. I was in a bit of a mess and she dressed my foot in my ute and then sent me off. It's because I had COVID. I didn't think that was fair that I should be treated that way. It was a long time and I can show you the photos of the burn. It was nasty.' (M, NZ European)
	Hospital needs to stay open	'I'm glad we've still got a hospital, put it that way; rather have what we've got now, than have nothing at all.' (M, Māori)

early in-person appointments were preferred and not available:

> Participant: Yeah. My question to that is how do you know you're gonna be sick in a month's time?
>
> Interviewer: That's quite a long way out, isn't it?
>
> Participant: It is. They told her [participant's wife] a month to get an appointment. … They tell you if you need a doctor straight away to go to the A&E. (M, NZ European/Pakeha)

At times, respondents experienced stigma using the rural hospital emergency department for what they perceived as minor complaints. They were aware of the hospital being oriented toward providing emergency and inpatient care but had limited other options:

> But sometimes you come in and you do feel like the nurses, even sometimes some doctors make you feel like you're not actually welcome here because you're not … even though you're feeling frustrated and you know that you're not meant to be there, you want the help, you just don't know where else to go or there's cost factors and then they make you feel like you're wasting [their] time, which is essentially what we already know by coming here but we don't wanna live with [health problem]. (F, NZ European/Pakeha)

Costs of primary and after-hours care, and difficulty navigating the primary care system were identified as other factors in the decision to attend the rural hospital.

For some participants, the hospital district nurses functioned as important alternative access points for acute care, providing a link for patients between hospital and primary care services, and as a quasi-triage function to assist with shared decision making about whether an issue required urgent attention at the emergency department, or whether they could continue with care in the community while waiting for general practitioner (GP) follow-up. Participants appreciated the convenience of having primary care, rural hospital and other health and social services co-located on the same site.

Facilitating family/whanau support

The easier access of family support when hospital care was local was highly valued. Respondents felt that family members could visit more easily with shorter travel times, family routines were less disrupted and time spent travelling out of district for family/whanau (extended family) to provide support was burdensome.

Participants spoke of the significant personal and financial cost of having to access hospital and other specialist care at a distance. This could involve arranging childcare and leave from employment, and, for many participants, it created significant financial pressures relating to unplanned expenses and loss of income. Participants with relatives hospitalised in the urban hospital described the challenges in contrast to the convenience of being able to visit when their relative was hospitalised locally:

> Interviewer: Would you have preferred to have had that treatment locally?
>
> Respondent: Absolutely, yes!
>
> Interviewer: What do you think the advantages would be of having that locally, if it was available?
>
> Respondent: You've got closer family ties, they're right here. You're not putting anyone out, they can come and see you, they don't have to take time off.
>
> Interviewer: It's much easier to go and visit someone down the road, isn't it?
>
> Respondent: Yeah, hop in the car and go all the way up to [urban centre] and visiting hours are 11 to 1 and then 4 to 8. (M, NZ European/Pakeha)

Providing personalised and culturally aware care

Participants suggested a role for rural hospitals in providing care tailored to personal circumstances, such as flexible visiting hours due to parental responsibilities or respecting privacy (Table 2).

Care in the rural hospital also appeared to be associated with culturally respectful practices for some participants. Māori and Pacific participants described positive experiences in the local rural hospital, where staff remained mindful of considering their cultural needs as part of their care.

> Like I said, I've been through the hospital and all that and the service, for me, they've always been pretty good. I've never felt uncomfortable or anything. They're always asking me whether or not I need to be seen to through my culture and all that, they're always asking different questions like that. (M, Māori)

However, some Pacific participants did not perceive the rural hospital to be meeting their cultural needs.

> I think you'll find though with Pacific, if you're in a setting, for example, my Dad, the doctor will be speaking to him, he's nodding his head – he doesn't understand what the doctor's saying. (F, Pacific)

This suggests that for some Pacific participants there was an expectation that staff would be cognisant of cultural behaviours, such as the need to appear agreeable in the example above, and how these cultural norms may have an impact on the nature of interactions with Pacific community members.

Doing the best with limited resources

Participants noted limitations to staff and services provided rurally. This was framed by participants in the context of the ongoing relationship between the community and the hospital over time. In particular, older participants talked about the effects of centralisation and the decline of services: participants expressed frustration that a common experience was to have initial investigations, stabilisation of their conditions and symptom relief for their presenting health issues, but a need then for transfer away from the rural community to the distant urban hospital to have definitive care for their issues.

> Yeah. A lot of our locals, me especially, I don't like to travel. I like to stay here in town. When [they] gotta chuck you in ambulance and shoot you off to somewhere else but it's a bit hard but that's how it is nowadays. I always prefer to stay here in [study community] but they just haven't got the facilities anymore now. (M, Māori)

Although participants were disappointed with the lack of local resourcing, they generally absolved frontline clinical staff of the blame for the situation and attributed it to policy failures from health managers and politicians. Participants were philosophical about the fact that health resources were

scarce relative to demand, and they had low expectations for improvement:

> I wish our hospital was back to what it was like 30 odd years ago. I know it probably won't but hopefully one day it might be. (M, Māori)

This study was undertaken towards the end of NZ's COVID-19 response, and participants described how the pandemic had changed the nature of interactions they had come to value from their rural hospital. The deleterious effects of the COVID-19 controls implemented by the hospital were felt particularly by the Pacific participants, for example, when rapid antigen tests were not available and the hospital was asking people to attend community testing centres for polymerase chain reaction testing:

> I was the site lead for the testing here in [rural community], …and a lot of the people that came down said they were sent from ED to be tested here before they could go back up there so I thought that was a bit unfair for them having to be sent to us just to be tested, just to go back there again. A lot of these people are the older people and so just getting them up to the hospital in the first place was hard enough but then having to be told to come down to the testing station to be tested, to be then told to go back up after they'd been tested, I thought that was unfair. (F, Pacific)

Despite ongoing challenges, hospital survival threats and the perception of a downgraded service, there was a strong sentiment that the hospital needed to continue to keep its doors open for the community:

> What I don't want to happen and come out of this discussion … is that we actually lose what we do have. We don't want to lose [rural hospital]. (F, Pacific)

Discussion

Findings from this study articulate several roles of the rural hospital, including providing backup emergency and urgent primary care access, reducing barriers to family support and catering to community members' personal and cultural needs. The continued presence of the rural hospital in some form was strongly desired by this community. The reasons may include a sense of community safety, given the significant access challenges to receiving urban-based and timely local rural primary health care as described by participants.

The presence of a rural hospital may reduce community anxiety about accessing timely emergency care without significant travel and cost burdens. This mirrors Canadian research of rural hospital closures in the 1990s where, prior to closure, communities perceived a potential threat to their health.[23] The rural hospital emergency department also played a role in mitigating difficulties created by the lack of timely primary care access and primary care costs[16] for this community. It Is unclear whether this is an important function of other rural hospitals or unique to the study hospital.

Some participants expressed appreciation for the layout of the study hospital site, which provided access to ancillary primary and community health services in the same location. The value attributed to co-location of health services echoes the findings of Blattner *et al.*,[24] in which rural hospital leadership advocated for a locally tailored approach, emphasising the blurred distinction between primary and secondary in rural health care, suggesting service planners should consider how rural hospital and primary care services can provide seamless navigation and better care coordination for the populations they serve.[25]

Rural hospitals have a role in facilitating family/whanau-centred care. Family support is known to be instrumental in enhancing recovery for patients during hospitalisation.[26] A recent systematic review of public health in NZ reported that for hospitalised Māori, whanau provide emotional and practical support and navigation of a system that can be experienced as culturally alienating and hostile. For whanau, provision of such support sometimes incurred significant personal or financial costs.[27] This is similar to a study of experiences of rural Aboriginal and Torres Strait Islander peoples hospitalised in Australian urban centres.[28]

In addition to the hospital providing personalised, family centred-care, participants expressed an expectation of care that respected their cultural needs. This is important for providing quality care to rural Māori and Pacific clients. Improving Māori outcomes through culturally safe practice and care[29] are widely accepted as professional obligations for health providers. A recent study of a Tuvaluan population in a rural NZ community found that rural-dwelling Pacific populations face additional challenges in accessing fit-for-purpose care when compared with urban-dwelling participants, and there is a need for rural health services to collaborate with Pacific communities.[30]

Indigenous models of health could be applied to conceptualise the relationships and roles of rural hospitals for Māori and Pacific consumers. The Meihana model[31] is an example of a comprehensive and widely applied framework for understanding Māori health and the interaction of spiritual, physical, psychological and cultural influences on the wellbeing of the Māori consumer. Existing Pacific models of health articulate health and wellbeing holistically. There is a variety of other models, each tending to articulate health and wellbeing specific to that particular culture.[32] Articulating an understanding of the role of health care, in particular the meaning and significance of receiving hospital care and how it pertains to Māori and Pacific worldviews

around the maintenance and restoration of health, may enhance the ability to provide culturally safe rural hospitals for these communities.

Participants were almost universal in acknowledging the limitations of services available in a rural hospital, and yet they voiced a clear sentiment that, despite these difficulties, the community needed to continue to have a hospital to serve it. Older participants described the progressive reduction in services over time as a result of demographic changes and policies that have led to centralisation of services, similar to that described by Barnett and Barnett[33] and in a rural Canadian case study.[34] The effects of centralisation on rural hopsitals and their communities could be further researched in the NZ context to understand the effects of such policies, the burden of unmet health need for rural populations and the health and social effects of travel to access secondary and tertiary care incurred by rural people. Understanding these effects on rural communities, and potential mitigations may inform service design in the context of current health reforms.[9]

International research identifies economic benefits resulting from the presence of rural hospitals and health services in communities in terms of direct employment and indirect effects of increased economic activity.[35] Notably, economic benefits were not mentioned by study participants despite the preponderance of health worker participants.

Strengths and limitations

The emphasis on community engagement was a strength of the study design. While this was a descriptive qualitative study of a single regional health authority–governed rural hospital, it is likely that findings would be relevant/transferable to rural hospitals in other regions and with differing governance models. Recruitment was reliant on professional and clinical networks and may have limited the variety of perspectives gained, for example, a preponderance of health professional participants and none under 30 years of age. Māori participation rates were lower than expected. The research team did not include Māori and/or Pacific researchers, which was a limitation of the study.

This qualitative study was exploratory and descriptive in nature and therefore limited in its potential to provide meaning-based interpretive understandings of community views on their rural hospital.[18] For example, further research using Māori and Pacific models of health and research methodologies, such as talanoa and Kaupapa Māori research, could provide enhanced understandings of lived experience for rural Māori and Pacific patients.[36]

Conclusion

Rural hospitals have significant community roles. They are an important part of the health care safety net, reducing geographical barriers to emergency care access and mitigating the effects of poor primary care access. Being situated in the local rural community, and with their highly developed local contextual knowledge, they are ideally placed to meet community expectations of accommodating personal and cultural preferences and facilitating family support. In the eyes of their communities, rural hospitals have significant potential health and social benefits. Current NZ health reforms provide an opportunity to consider how these services can be maintained and enhanced, and how they can provide their communities with accessible, patient-centred, timely and culturally safe care.

References

1 The Royal New Zealand College of General Practitioners. Rural Hospital Medicine Training Programme Handbook. Wellington, New Zealand: The Royal New Zealand College of General Practitioners; 2020. Available at https://www.rnzcgp.org.nz/GPdocs/New-website/become_a_GP/DRHM_Handbook_2020.pdf [Accessed 2020].

2 Blattner K, Clay L, Nixon G, Richard L, Miller R, Crengle S, Anton R, Stokes T. The place of rural hospitals in New Zealand's health system: an exploratory qualitative study. *Rural Remote Health*. 2023 Apr; 23(2): 7583. doi:10.22605/RRH7583

3 Whitehead J, Blattner K, Miller R, *et al.* Defining catchment boundaries and their populations for Aotearoa New Zealand's rural hospitals. *J Prim Health Care* 2023; 15: 14–23. doi:10.1071/HC22133

4 Crengle S, Davie G, Whitehead J, *et al.* Mortality outcomes and inequities experienced by rural Māori in Aotearoa New Zealand. *Lancet Reg Health West Pac* 2022; 28: 100570. doi:10.1016/j.lanwpc.2022.100570

5 Ministry of Health, New Zealand. Ola Manuia: Pacific health action plan 2020-2025. Ministry of Health, editor. Wellington, NZ: Ministry of Health; 2020.

6 Blattner K, Clay L, Miller R, *et al.* New Zealand's rural hospitals in 2021: findings from an exploratory questionnaire survey. *J Prim Health Care* 2022; 14: 254–8. doi:10.1071/HC22072

7 Williamson M, Gormley A, Dovey S, *et al.* Rural hospitals in New Zealand: results from a survey. *N Z Med J* 2010; 123(1315): 20–9.

8 Blattner K, Miller R, Lawrence-Lodge R, *et al.* New Zealand's vocational rural hospital medicine training programme: the first ten years. *N Z Med J* 2021; 134(1529): 57–68.

9 Transition Unit Ministry of Health, New Zealand. White paper: Our Health and Disability System. In: Cabinet DotPMa, editor. Wellington, New Zealand: New Zealand Government; 2021.

10 Little A. Pae Ora (Healthy Futures) Bill [Government Bill]. Wellington; 2022. Available at https://legislation.govt.nz/bill/government/2021/0085/latest/LMS575405.html

11 Whitehead J, Blattner K, Miller R, *et al.* Defining catchment boundaries and their populations for Aotearoa New Zealand's rural hospitals. *J Prim Health Care* 2023; 15(1): 14–23. doi:10.1071/HC22133

12 Whitehead J, Davie G, de Graaf B, *et al.* Defining rural in Aotearoa New Zealand: a novel geographic classification for health purposes. *N Z Med J* 2022; 135(1559): 24–40.

13 Hauora Taiwhenua Rural Health Network. Becoming Hauora Taiwhenua Rural Health Network. Our journey: Hauora Taiwhenua. 2023. Available at https://htrhn.org.nz/our-journey/ [updated 2023].

14 Goodyear-Smith F, Ashton T. New Zealand health system: universalism struggles with persisting inequities. *Lancet* 2019; 394(10196): 432–42. doi:10.1016/S0140-6736(19)31238-3

15 Houkamau CA. What you can't see can hurt you: how do stereotyping, implicit bias and stereotype threat affect Maori health. *MAI J* 2016; 5: 124–36. doi:10.20507/MAIJournal.2016.5.2.3

16 Gauld R, Atmore C, Baxter J, *et al.* The 'elephants in the room' for New Zealand's health system in its 80th anniversary year: general practice charges and ownership models. *N Z Med J* 2019; 132(1489): 8–14.

17 Koerber A, McMichael L. Qualitative sampling methods: a primer for technical communicators. *J Bus Tech Commun* 2008; 22(4): 454–73. doi:10.1177/1050651908320362

18 Braun V, Clarke V. Toward good practice in thematic analysis: avoiding common problems and be(com)ing a knowing researcher. *Int J Transgend Health* 2023; 24(1): 1–6. doi:10.1080/26895269.2022.2129597
19 Richards H, Emslie C. The 'doctor' or the 'girl from the University'? Considering the influence of professional roles on qualitative interviewing. *Fam Pract* 2000; 17(1): 71–5. doi:10.1093/fampra/17.1.71
20 Birt L, Scott S, Cavers D, *et al.* Member checking: a tool to enhance trustworthiness or merely a nod to validation? *Qual Health Res* 2016; 26(13): 1802–11. doi:10.1177/1049732316654870
21 Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006; 3(2): 77–101. doi:10.1191/1478088706qp063oa
22 Bukamal H. Deconstructing insider–outsider researcher positionality. *Br J Spec Educ* 2022; 49(3): 327–49. doi:10.1111/1467-8578.12426
23 Liu L, Hader J, Brossart B, *et al.* Impact of rural hospital closures in Saskatchewan, Canada. *Soc Sci Med* 2001; 52(12): 1793–804. doi:10.1016/s0277-9536(00)00298-7
24 Blattner K, Clay L, Nixon G, *et al.* The place of rural hospitals in New Zealand's health system: an exploratory qualitative study. *Rural Remote Health* 2023; 23(2): 7583. doi:10.22605/RRH7583
25 Atmore C, Dovey S, Gauld R, *et al.* What is important for high quality rural health care? A qualitative study of rural community and provider views in Aotearoa New Zealand. *Rural Remote Health* 2023; 23(1): 7635. doi:10.22605/RRH7635
26 Fakhry M, Mohammed WE. Impact of family presence on healthcare outcomes and patients' wards design. *Alexandria Eng J* 2022; 61(12): 10713–26. doi:10.1016/j.aej.2022.04.027
27 Graham R, Masters-Awatere B. Experiences of Māori of Aotearoa New Zealand's public health system: a systematic review of two decades of published qualitative research. *Aust N Z J Public Health* 2020; 44(3): 193–200. doi:10.1111/1753-6405.12971
28 Cummins R, Preston R, Topp SM, *et al.* A qualitative exploration of the non-financial costs of cancer care for Aboriginal and Torres Strait Islander Australians. *Aust N Z J Public Health* 2023; 47(5): 100085. doi:10.1016/j.anzjph.2023.100085
29 Curtis E, Jones R, Tipene-Leach D, *et al.* Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *Int J Equity Health* 2019; 18(1): 174. doi:10.1186/s12939-019-1082-3
30 Tafaaki J. The Lived Experiences of Rural Tuvaluans Navigating the Aotearoa New Zealand Healthcare System. PhD Thesis. Dunedin, NZ: University of Otago; 2022.
31 Pitama S, Huria T, Lacey C. Improving Maori health through clinical assessment: Waikare o te Waka o Meihana. *N Z Med J* 2014; 127(1393): 107–19.
32 Agnew F, Pulotu-Endemann K, Robinson G, *et al.* Pacific Models of Mental Health Service Delivery in New Zealand ("PMMHSD") Project. Auckland: Waitemata District Health Board Auckland, Centre CRaR; 2004.
33 Barnett R, Barnett P. "If you want to sit on your butts you'll get nothing!" Community activism in response to threats of rural hospital closure in southern New Zealand. *Health Place* 2003; 9(2): 59–71. doi:10.1016/s1353-8292(02)00019-9
34 Grafton D, Troughton M, Rourke J. Rural community and health care interdependence: an historical, geographical study. *Can J Rural Med* 2004; 9(3): 156–63.
35 Doeksen GA, Schott V. Economic importance of the health-care sector in a rural economy. *Rural Remote Health* 2003; 3(1): 135.
36 Curtis E. Indigenous positioning in health research: the importance of Kaupapa Maori theory-informed practice. *AlterNative* 2016; 12(4): 396–410. doi:10.20507/AlterNative.2016.12.4.5

Data availability. Anonymised data used to generate results of the paper are available from the corresponding author on request.

Disclaimer. The views expressed in the submitted article are the authors' own and not an official position of funders, James Cook University or Te Whatu Ora Waikato.

Conflicts of interest. The authors declare no conflicts of interest.

Declaration of funding. Funding grants from Research and Education Committee, The Royal New Zealand College of General Practitioners (June 2023) and Waikato Medical Research Foundation (#344).

Author affiliations

[A]Tokoroa Hospital, Te Whatu Ora (Health New Zealand) Waikato District, Maraetai Road, Tokoroa, New Zealand.

[B]James Cook University, Townsville, Qld, Australia.

[C]University of Otago, Dunedin, New Zealand.